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ABSTRACT

The General Accounting Office reviewed the effects of major legislative changes on Medicare and Medicaid program costs and the out-of-pocket costs to the programs' beneficiaries. Cf 30 laws that affected Medicare and Medicaid enacted by Congress during the period 1980 through 1986, 5 were estimated to have the greatest effects on the costs of the two programs. Medicare cost growth trends were compared before and after the legislation for inpatient hospital care under Medicare part A and part B services. The results suggest that the five major laws passed during 1980 through 1986 contributed to a slowdown in Medicare cost growth during fiscal years 1981 through 1985 as compared with 1970 through 1980 data. Fiscal year 1982 Medicaid costs increased about 8 percent over 1981, a decline from the average annual cost growth rate of about 15 percent from 1973 through 1981. Some legislation contributed to the trend among states to increase Medicaid costs by expanding program eligibility and services. From 1980 through 1985, Medicare beneficiary average out-of-pocket costs increased about 49 percent for part A services and about 31 percent for part B services. Much of this increase could be attributed to legislation. Although the change in Medicaid recipient out-of-pocket costs could not be measured, it was found that many states expanded their cost-sharing requirements since certain legislative enactment. (NB)

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United States General Accounting Office

GAO

Report to the Chairman, Select Committee on Aging, House of Representatives

April 1987

MEDICARE AND MEDICAID

Effects of Recent Legislation on Program and Beneficiary Costs

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United States
General Accounting Office
Washington, D.C. 20548

Human Resources Division

B-226390

April 8, 1987

The Honorable Edward R. Roybal
Chairman, Select Committee on Aging
House of Representatives

Dear Mr. Chairman:

This report is in response to your February 26, 1986, request. The report discusses the effects of major legislation since 1980 on Medicare and Medicaid program costs and on beneficiary out-of-pocket costs.

As arranged with your office, unless you publicly announce its contents earlier, we plan no further distribution of this report until 5 days from its issue date. At that time we will send copies to interested parties and make copies available to others upon request.

Sincerely yours,

Richard L. Fogel
Assistant Comptroller General

Executive Summary

Purpose

During the 1970's, Medicare and Medicaid program costs grew rapidly—Medicare costs rose from about $6.9 billion in fiscal year 1970 to about $28.2 billion in fiscal year 1979, while Medicaid expenditures rose from about $4.6 billion to about $20.5 billion. In the following 7 years, 1980 through 1986, the Congress made major legislative changes that were expected to significantly affect the trend in cost growth of these two health insurance programs.

The Chairman, House Select Committee on Aging, asked GAO to review the effects of major legislative changes from 1980 onward on Medicare and Medicaid program costs and the out-of-pocket costs to the programs' beneficiaries.

Background

Medicare is a federal program that assists most of the elderly and some disabled people in paying for their health care. The program provides two basic forms of protection. Part A, Hospital Insurance, covers inpatient hospital services, posthospital care in skilled nursing facilities, hospice care, and care in patients' homes. In fiscal year 1985, Medicare part A covered about 30.6 million enrollees, and benefits amounted to about $46 billion.

Part B, Supplementary Medical Insurance, covers physician services and a variety of other health care services, such as laboratory and outpatient hospital services. In fiscal year 1985, Medicare part B covered about 30 million enrollees, and benefits totalled about $21.9 billion.

Medicaid is a grant-in-aid program under which the federal government pays from 50 to 78 percent of state costs for medical services provided to low-income people who are unable to pay for their medical care. Medicaid is administered by each state within broad federal guidelines. In fiscal year 1985, about 21.8 million persons received Medicaid assistance, totaling about $37.5 billion.

During the period 1980 through 1986, the Congress enacted more than 30 laws that affected the Medicare and Medicaid programs. The Congressional Budget Office (CBO) and the Health Care Financing Administration (HCFA), the agency within the Department of Health and Human Services responsible for administering Medicare and Medicaid, estimated that five of these laws would have the greatest effects on the cost of the two programs—the Omnibus Reconciliation Act of 1980, the Omnibus

Budget Reconciliation Act of 1981, the Tax Equity and Fiscal Responsibility Act of 1982, the Deficit Reduction Act of 1984, and the Consolidated Omnibus Budget Reconciliation Act of 1985.

Results in Brief

GAO estimates that, had prior cost growth trends continued, actual inflation-adjusted Medicare costs may have been about $13 billion more during the period 1981 through 1985 than they actually were. GAO believes that the major legislative changes played an important role in this slowdown in Medicare cost growth.

The five major laws were expected to have a mixed effect on Medicaid program costs—two of the laws passed early in the period were expected to result in savings; the other three were expected to increase program costs. The actual Medicaid cost experience for fiscal years 1981 through 1985 shows that program cost growth generally was affected as projected—a sharp decline in the rate of growth in fiscal year 1982 (from 16.8 percent the previous year to about 8.1 percent) followed by increases later in the period, which were still lower than the historical trend.

The average inflation-adjusted out-of-pocket cost per Medicare enrollee for Medicare-covered services increased between 1980 and 1985 by about 49 percent for part A services and about 31 percent for part B services. GAO believes that most of the increase in beneficiary costs can be attributed to the major legislation enacted during the period.

Varying state cost-sharing requirements and nonavailability of state data precluded an analysis of the change in Medicaid recipients' out-of-pocket costs. However, 26 states have increased cost-sharing requirements for Medicaid recipients as a result of the Tax Equity and Fiscal Responsibility Act of 1982.

GAO Analysis

Medicare Costs

Because of the numerous interrelated factors affecting Medicare costs, such as lower utilization of inpatient hospital services, GAO did not attempt to quantify the change in Medicare costs specifically attributable to the major legislative changes. Rather, GAO compared cost growth trends before and after the legislation for inpatient hospital care under

part A and for part B services. The costs of these services represented about 96 percent of total Medicare costs in fiscal year 1985.

For part A inpatient hospital costs, GAO analyzed the 1970 through 1980 inflation-adjusted cost data and used the results to predict what the yearly costs would have been for the period 1981 through 1985 if the pre-1980 cost growth trend had continued. GAO compared the predicted costs with the actual costs for the period and estimated that total Medicare inpatient hospital costs of about $210 billion would have been about $11.5 billion more (in constant 1985 dollars) than they actually were. (See pp. 21-22.)

GAO also analyzed prior period cost data to predict the cost of part B services for fiscal years 1984 and 1985—the 2 years most affected by the legislative changes. GAO compared the predicted cost with the actual costs for those 2 years and estimated that, had the growth rate from the prior period continued, total part B costs of about $43 billion would have been about $1.7 billion more (in constant 1985 dollars) than they actually were. (See p. 25.)

Medicaid Costs

Although each of the five major laws was expected to reduce Medicare cost outlays, this was not the case with Medicaid. Laws enacted earlier in the period, primarily the Omnibus Budget Reconciliation Act of 1981, encouraged states to control program costs. In part, because of this law, fiscal year 1982 Medicaid costs increased only about 8 percent over the previous year. This was a sharp decline from the cost growth rate that averaged about 15 percent from 1973 through 1981. In contrast, the trend among states from 1983 to 1985 was to increase Medicaid costs by somewhat expanding program eligibility and services. Legislation enacted later in the period, primarily the Deficit Reduction Act of 1984, contributed to this trend. (See p. 33.)

Beneficiary Costs

Under Medicare part A, beneficiaries pay a deductible for inpatient hospital services and coinsurance for extended hospital and skilled nursing facility stays. Laws enacted during the period increased the part A deductible and coinsurance amounts, thus helping to increase average out-of-pocket costs per enrollee for part A services from $84 (in constant 1985 dollars) in 1980 to $125 in 1985, an increase of about 49 percent.

Under Medicare part B, beneficiaries pay monthly premiums, an annual deductible, and coinsurance. Again, the major legislation increased the amounts paid for each of these items, thus contributing to the increase in average out-of-pocket costs for part B services from $395 (in constant 1985 dollars) in 1980 to $516 in 1985, an increase of about 31 percent.

Beneficiaries are also liable for services and health needs not covered by Medicare, such as long-term care, dental care, prescription drugs, and hearing aids. GAO did not analyze the change in beneficiary out-of-pocket costs for noncovered services.

The Tax Equity and Fiscal Responsibility Act of 1982 expanded Medicaid cost-sharing options available to the states, and many states expanded their cost-sharing requirements for Medicaid recipients. During the period September 1982 to December 1985, 26 states took 34 policy actions to adopt or expand a program where Medicaid recipients pay nominal amounts (generally from $.50 to $3) for health services. As of December 1985, 28 states and the District of Columbia had copayment programs, while 22 states did not.

Recommendations

This report provides GAO's analysis of the effect of recent legislation on Medicare and Medicaid program costs and on the out-of-pocket costs to the programs' beneficiaries; it includes no recommendations.

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Abbreviations

CBO	Congressional Budget Office
COBRA	Consolidated Omnibus Budget Reconciliation Act of 1985
DEFRA	Deficit Reduction Act of 1984
GAO	General Accounting Office
HCFA	Health Care Financing Administration
HHA	home health agency
HHS	Department of Health and Human Services
OBRA	Omnibus Budget Reconciliation Act of 1981
ORA	Omnibus Reconciliation Act of 1980
PPS	prospective payment system
SNF	skilled nursing facility
TEFRA	Tax Equity and Fiscal Responsibility Act of 1982

Chapter 1

Introduction

The Chairman, House Select Committee on Aging, requested that we study the effect of federal cost containment efforts on the Medicare and Medicaid programs and their beneficiaries. Specifically, he asked us to (1) review the significant legislative changes to the two programs from 1980 onward and (2) determine the effects of each change on program costs and on beneficiary out-of-pocket costs. The Chairman also requested that we provide data on the budgetary reductions resulting from the Gramm-Rudman-Hollings law, the number of providers participating in Medicare for fiscal years 1980 and 1985, and the average use rates for various services.

The Medicare Program

Medicare is a federal program (authorized as effective on July 1, 1966, by title XVIII of the Social Security Act) that assists most of the elderly and some disabled people in paying for their health care. The program provides two basic forms of protection:

- Part A, Hospital Insurance, which is financed primarily by Social Security payroll taxes, covers inpatient hospital services, posthospital care in skilled nursing facilities (SNFs), hospice care, and care provided in patients' homes. In fiscal year 1985, Medicare part A covered 30.6 million enrollees and benefits amounted to about $46 billion. About $43 billion (94 percent) of part A expenditures were for inpatient hospital services.
- Part B, Supplementary Medical Insurance, which is a voluntary program financed by enrollee premiums (25 percent of total costs) and federal general revenues, covers physician services and a variety of other health care services, such as laboratory and outpatient hospital services. In fiscal year 1985, Medicare part B covered 30 million enrollees, and benefits totalled about $21.9 billion.

Although the scope and coverage of medical services under Medicare is quite broad, there are considerable beneficiary cost-sharing provisions, and there is no catastrophic limit on medical expenses paid by the beneficiary. Under part A, the beneficiary is required to pay a deductible for inpatient hospital stays, $520 during 1987. In addition, for extended hospital and nursing home stays, beneficiaries pay a per day amount called coinsurance. (The deductible and coinsurance amounts for the years 1980 through 1987 are shown in table 4.2 on p. 37.)

Under part B, the beneficiary is required to pay a monthly premium to establish eligibility. Beginning in 1967, the premium was recalculated each odd-numbered year to produce an amount equal to one-half the

projected average monthly cost per enrollee of the part B program. The Social Security Amendments of 1972 (Public Law 92-603) provided that the part B premium could not increase by more than the percentage increase in Social Security retirement benefits. Under this provision, the enrollees' portion of total part B costs steadily decreased until it was less than 25 percent in 1982. The Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) (Public Law 97-248) changed the calculation for two 1-year periods beginning in July 1983, requiring that the premium produce an amount equal to 25 percent of the projected average monthly cost of the part B program. The Deficit Reduction Act of 1984 (DEFRA) (Public Law 98-369) extended this requirement through 1987 and provided that the increase in the part B premium be limited to the dollar amount of the Social Security cost-of-living adjustment. Users of part B services are also required to pay an annual deductible of $75. Before 1982 the annual deductible was $60.

Medicare part B pays for covered services by reimbursing the physician or supplier directly (assigned claims) or reimbursing the beneficiary (unassigned claims). When physicians or suppliers accept assignment, they agree to accept the Medicare determination of reasonable charges as payment in full, and the beneficiary is responsible for paying 20 percent of the reasonable charge (plus any unmet deductible for the year). On unassigned claims the beneficiary is also responsible for the difference between Medicare's reasonable charge and the physician's or supplier's charge.

Under Medicare, the reasonable charge for a service is the lowest of

- the actual charge for the service;
- the customary charge, which is the amount the physician or supplier usually charges for the service; or
- the prevailing charge, which is an amount high enough to cover 75 percent of all the charges for the service in a specific geographic area.

Reasonable charges are normally updated annually to reflect changes in charges. Through fiscal year 1983 these updates occurred on July 1 of each year. Reasonable charges were frozen by DEFRA at the levels in effect on June 30, 1984, for the period July 1, 1984, through September 30, 1985. This freeze was extended several times; the latest extension was to December 31, 1986, by the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) (Public Law 99-272). Currently, updates are to be made on January 1 of each year.

The Health Care Financing Administration (HCFA), within the Department of Health and Human Services (HHS), is responsible for administering Medicare, establishing policy, and developing operating guidelines. HCFA operates the program with assistance from insurance companies, called intermediaries under part A and carriers under part B. The insurance companies process and pay claims for covered services.

The Medicaid Program

Title XIX of the Social Security Act authorizes the Medicaid program, which began on January 1, 1966. Medicaid is a grant-in-aid program under which the federal government pays from 50 to 78 percent of state costs for medical services provided to low-income people unable to pay for their medical care. Currently, all 50 states,[1] the District of Columbia, American Samoa, Guam, Puerto Rico, the Northern Mariana Islands, and the Virgin Islands have Medicaid programs.

Two groups of people can be covered by Medicaid. The first group, known as the categorically needy, receives or is eligible to receive public assistance under one of the cash assistance programs (Aid to Families with Dependent Children and Supplemental Security Income). Those actually receiving cash assistance must be covered by the state's Medicaid program. A state can also elect Medicaid coverage for the second group, the medically needy. These are people who meet all of the requirements of a cash assistance program except that their income exceeds the cash assistance level by not more than one third, after deducting medical expenses. As of October 1985, 34 states and four jurisdictions had medically needy programs. In fiscal year 1985, about 21.8 million persons received Medicaid assistance totaling about $37.5 billion.

The states are responsible for initiating and administering their Medicaid programs within broad federal guidelines. The nature and scope of a state's Medicaid program are contained in a state plan which, after approval by HHS, provides the basis for federal funds to the state. Some states administer the entire program through their state agencies; others contract with private organizations to help administer their programs. The contractors, called fiscal agents, have responsibilities that vary depending on the contractual arrangements established by the states.

[1]Arizona was the last state to adopt a Medicaid program. The Arizona program is operated under a waiver of certain federal requirements.

Under the Medicaid program, participating states are required to provide those eligible with the following services: inpatient and outpatient hospital, laboratory and x-ray, SNF, physician, home health care, family planning, nurse-midwife, and early and periodic screening for children. Additional services, such as dental care and prescribed drug, may be included under a Medicaid program if a state so chooses.

Out-of-pocket costs to Medicaid recipients can include coinsurance, deductibles, enrollment fees, copayments, and premiums; states can require recipients to pay any of these. Before 1982 cost-sharing was generally limited to optional services. TEFRA, however, permitted the states to require cost-sharing for nearly all services (mandated as well as optional) offered under a state plan. TEFRA provided that the cost-sharing amounts must be nominal (see p. 40) and that no more than one type of charge could be imposed on any service. By the end of 1985, 26 states took 34 policy actions to adopt or expand cost-sharing requirements, while 12 states had eliminated or relaxed cost-sharing requirements.

Legislative Changes to the Medicare and Medicaid Programs

During 1980 through 1986, the Congress enacted more than 30 laws that affected the Medicare and Medicaid programs (see app. I). The five laws that the Congressional Budget Office (CBO) and HCFA estimated to have the greatest effects on the cost of the two programs through fiscal year 1986 are the following:

- Omnibus Reconciliation Act of 1980 (ORA) (Public Law 96-499), enacted Dec. 5, 1980;
- Omnibus Budget Reconciliation Act of 1981 (OBRA) (Public Law 97-35), enacted Aug. 13, 1981;
- Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) (Public Law 97-248), enacted Sept. 3, 1982;
- Deficit Reduction Act of 1984 (DEFRA) (Public Law 98-369), enacted July 18, 1984; and
- Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) (Public Law 99-272), enacted Apr. 7, 1986.

The Social Security Amendments of 1983 (Public Law 98-21) also affected the Medicare program by changing the method of paying hospitals. This legislation established the Medicare hospital prospective payment system (PPS). PPS replaced the Medicare cost reimbursement system for most hospitals and established predetermined payment rates for each of 468 diagnosis related groups. In addition, PPS required payments

to hospitals to be budget neutral—neither increasing nor decreasing Medicare costs—and both CBO and HCFA projected that this would be the result. It appears, however, that PPS has helped slow the rate of growth in Medicare costs (see p. 23).

The Omnibus Budget Reconciliation Act of 1986 (Public Law 99-509), enacted October 21, 1986, will also affect the Medicare and Medicaid programs beginning in fiscal year 1987. CBO estimated that this act would increase Medicare costs by $495 million and Medicaid costs by $170 million in fiscal year 1987.

Objectives, Scope, and Methodology

The Chairman's February 26, 1986, request letter asked us to provide

- a listing of all significant changes in Medicare and Medicaid law from 1980 onward; the originally estimated effect on program and beneficiary costs; and, to the extent possible, the actual effects of each change;
- a listing of major program regulatory changes not directly related to a change in law, along with the estimated effect on program and beneficiary costs;
- an estimate of the cumulative effects of these laws and regulatory changes on program costs and on beneficiary out-of-pocket costs;
- baseline data for the first round of reductions under Gramm-Rudman-Hollings and the budgetary reductions resulting from that round; and
- data for fiscal years 1980 and 1985 on the number of providers participating in Medicare and average use rates for the various services covered by the program.

We agreed with the Committee's office to limit our detailed analysis to five major laws (see p. 13) that CBO and HCFA estimated would have the greatest effect on the Medicare and Medicaid programs through fiscal year 1986.[2] Further, because of the numerous regulatory changes and their primary relationship to implementing the five major laws, it was agreed that an analysis of the regulatory changes was not necessary.

We did our work at HCFA's central office in Baltimore, where we obtained the HCFA estimates of the effects of the major laws and data on Medicare and Medicaid costs, enrollment, and utilization. We did not verify the HCFA cost, enrollment, and utilization data, but we have no reason to

[2]The Social Security Amendments of 1983 (Public Law 98-21), which established PPS, were not part of our detailed analysis because CBO and HCFA projected it to be budget neutral. However, we believe this law helped slow the rate of Medicare cost growth; it is discussed briefly on pp. 17 and 23.

doubt their accuracy. We did discuss the information obtained with HCFA program and actuarial officials.

We also performed work at CBO, where we obtained budgetary estimates of the effect, through fiscal year 1986, of the five laws on the Medicare and Medicaid programs; we discussed the estimates with CBO officials. As agreed with your office, we obtained information on the Maryland and Georgia Medicaid programs through interviews with state officials and a review of their annual reports and other information relating to beneficiary costs.

To determine the potential effect of the legislative changes on Medicare part A program costs, we analyzed the inpatient hospital cost data for fiscal years 1970 through 1980 (adjusted for inflation); we used this analysis as a basis for estimating what the cost per Medicare enrollee would have been for fiscal years 1981 through 1985 if costs had continued to grow at the same rate as compared with fiscal years 1970 through 1980. We then compared these estimates with the actual cost per enrollee during 1981 through 1985. We also analyzed the Medicare part B cost per enrollee for fiscal years 1973 through 1983 as a basis for projecting the costs for fiscal years 1984 and 1985 (the 2 years most affected by the legislative changes).

Because data were not available for fiscal year 1986, our analysis of the actual growth in parts A and B benefit costs is through fiscal year 1985. Thus, our analysis of this growth includes only four of the five major laws because COBRA was not passed until fiscal year 1986 (April 7, 1986). More details about our analyses are presented in chapter 2.

As requested by the Committee's office, we did not obtain official agency comments on this report. We conducted this review during the period April 1986 to December 1986, and our work was done in accordance with generally accepted government auditing standards.

Effects of Five Major Laws on Medicare Costs

CBO estimated that the five major laws enacted during 1980 through 1986 would reduce Medicare cost outlays by about $22 billion; HCFA estimated $21 billion. Neither CBO nor HCFA has analyzed the actual effects of the five laws on Medicare costs.

Our analysis of Medicare costs shows that there was a slowdown in cost growth during fiscal years 1981 through 1985 as compared with fiscal years 1970 through 1980. A lower average inflation rate, lower utilization of inpatient hospital services, and the major legislative changes contributed to the slowdown. Because of the interrelationship of these and other factors affecting Medicare costs, we did not attempt to quantify the amount of cost reductions attributable to the legislative changes.

Estimated Effects of Five Major Laws on Medicare

Each of the five major laws enacted during 1980 through 1986 was expected to result in Medicare savings. ORA was the first of these laws. CBO estimated that the Medicare provisions of this law, enacted December 5, 1980, would reduce program costs by a total of about $2.3 billion during fiscal years 1981 through 1985.

A major saving provision of this act required that the determination of Medicare reasonable charges for physician services be based on the date the service was rendered rather than the date that the claim was processed. This provision was expected to reduce Medicare outlays in cases where the services were provided before the annual reasonable charge update (see p. 11), but the claims were not processed until after the update, when the higher updated reasonable charges were in effect. The law also made Medicare the secondary payor for people whose medical expenses were covered by an automobile or liability insurance plan. CBO did not estimate savings for the individual provisions of this law.

CBO estimated that the provisions of OBRA, the second major law, would reduce Medicare costs by $3.2 billion during fiscal years 1981 through 1984. One of the act's major provisions reduced the routine nursing salary cost differential[1] paid to hospitals from 8.5 percent to a maximum of 5 percent. In addition, this law increased the part B deductible from $60 to $75 beginning in calendar year 1982. Again, CBO savings estimates for the individual provisions of this law were not available.

[1]Medicare's inpatient hospital cost reimbursement methodology had assumed that elderly patients used more routine nursing services than other patients and, therefore, paid hospitals more for these services. There were questions about the accuracy of this assumption. See Do Aged Medicare Patients Receive More Costly Routine Nursing Services? Evidence Inconclusive (GAO/HRD-82-32, Jan. 20, 1982).

Of the five major laws, TEFRA was estimated to have the greatest effect on Medicare costs. CBO estimated that the provisions of this law would reduce program costs by a total of $12.8 billion during fiscal years 1983 through 1985. Among other changes, TEFRA established a target rate reimbursement system for hospital services; this system limited the rate of increase in Medicare payments per case for a 3-year period beginning October 1, 1982. CBO estimated that this provision would save Medicare a total of about $6 billion in fiscal years 1983 through 1985. PPS was structured to be budget-neutral because it continued the limits set under TEFRA provisions; therefore, the TEFRA savings were estimated to still be in effect.

TEFRA also required employers to offer their employees (and their spouses) who are 65 through 69 years of age the same group health plans that are offered to younger workers. TEFRA made Medicare the secondary payor for these older employees who elect the plan. CBO estimated this provision would save the Medicare program about $1.5 billion through fiscal year 1985. Other major provisions of TEFRA that were expected to achieve significant savings included the following: reimbursing for radiologist and pathologist services provided to hospital inpatients at 80 percent of the reasonable charge rather than at 100 percent ($620 million), temporary suspension of the provision that limited the annual increase in part B premiums to the same percentage as the increase in Social Security retirement benefits ($765 million), and eliminating the routine nursing salary differential[2] paid to hospitals and SNFs ($330 million).

DEFRA also had a number of provisions that were expected to have a significant effect on Medicare costs. In total, CBO estimated that the provisions of this law would save the program $3.3 billion during fiscal years 1984 through 1986. Among other changes, DEFRA established a reimbursement fee schedule for outpatient laboratory services. Before this change, Medicare reimbursement for outpatient laboratory services was on the basis of reasonable charges. CBO estimated that the fee schedule would reduce Medicare outlays by a total of about $580 million in fiscal years 1984 through 1986. DEFRA also froze physician fees for a 15-month period beginning July 1, 1984. CBO estimated that the physician fee freeze would save Medicare about $1.6 billion through fiscal year 1986.

[2]See footnote 1.

In addition, DEFRA required employer-sponsored group health plans to cover employees' spouses who are 65 through 69 years of age (even though the employee is under the age of 65). Because Medicare would be the secondary payor for such spouses, CBO estimated that Medicare outlays would be reduced by a total of about $640 million in fiscal years 1985 and 1986.

CBO also estimated that the provisions of COBRA would reduce program costs by $463 million in fiscal year 1986. COBRA reduced the amount Medicare reimburses hospitals for the indirect costs of medical education. COBRA also limited the increase in the PPS payment rates to 1 percent for the remainder of fiscal year 1986; for fiscal years 1987 and 1988, the increase was limited to the increase in the hospital market basket index (a measure of price change in goods and services purchased by hospitals). COBRA further expanded the coverage requirement for employer group health plans by requiring that health insurance be offered to employees and their spouses over 69 years of age, thereby removing the upper age limit. This provision was expected to significantly reduce Medicare costs by increasing the population for whom Medicare is the secondary payor for health services. COBRA added to program costs by increasing payment amounts for hospitals serving a disproportionate share of low-income patients. CBO cost estimates for the individual provisions of COBRA were not available.

CBO's and HCFA's estimated cumulative savings for each of these five public laws for fiscal years 1981 through 1986 are shown in table 2.1. HCFA savings estimates, by provision, for each of the five laws, are shown in appendix II.

Table 2.1: CBO and HCFA Estimated Medicare Savings From Five Major Laws

Dollars in billions

Major law	Date passed	Cumulative savings, fiscal years 1981 through 1986[a] CBO	HCFA
ORA	Dec. 5, 1980	$2.3	$0.7
OBRA	Aug. 13, 1981	3.2	4.0
TEFRA	Sept. 3, 1982	12.8	14.0
DEFRA	July 18, 1984	3.3	2.1
COBRA	Apr. 7, 1986	0.5	0.2
Total		**$22.1**	**$21.0**

[a]These multiyear savings estimates, made as each of the five laws was enacted, were based on the economic assumptions in use at the time of enactment. Over time, these assumptions have been revised, and the savings estimates would probably change if the effect of the laws had been reestimated on the revised assumptions. However, reestimates of all of the laws covered here have not been made; therefore, the figures given are those contained in the original estimates.

Actual Effects of Five Major Laws Not Measured

We were unable to obtain the data necessary to estimate the actual effect of legislative changes on Medicare costs. Instead, we compared the trend in Medicare cost growth in the years before the laws became effective with the trend in the years since. Based on this analysis, we estimated that actual inflation-adjusted Medicare costs were about $13 billion less (measured in 1985 dollars) in the years after the laws became effective than they would have been had the prior cost growth trend continued. For a variety of reasons, this estimate is not comparable with the CBO and HCFA projections noted previously. The CBO and HCFA projections were made when the five major laws were enacted and cover the period fiscal years 1981 through 1986. Because actual cost data for fiscal year 1986 were unavailable, our estimate is for 1981 through 1985; it thus covers only four of the five laws because, as mentioned earlier, COBRA was not passed until fiscal year 1986. In addition, our estimate was calculated in constant 1985 dollars whereas the CBO and HCFA estimates are in current dollars, based on inflation projections these agencies were using at the time the estimates were prepared. Finally, our estimate includes the effect of all factors that affected the growth rate of Medicare costs, and is not an estimate of the independent effect of the legislative changes.

Decrease in Rate of Cost Increase for Medicare

Total Medicare benefits increased about 96 percent during fiscal years 1980 through 1985. Part A benefit costs increased from $24.1 billion in fiscal year 1980 to $45.9 billion in fiscal year 1985, and part B benefit costs increased from $10.5 billion to $21.9 billion. During the same

period, enrollees under part A increased 8.9 percent and enrollees under part B increased 9.5 percent. The total benefit cost, the number of enrollees, and change in cost per enrollee in the Medicare program during fiscal years 1980 through 1985 are shown in table 2.2.

Table 2.2: Medicare Experience, Fiscal Years 1980 Through 1985

Fiscal year	Total benefit cost (millions)	Number of enrollees (millions)	Cost per enrollee	Growth rate in cost per enrollee (in percent)
Part A				
1980	$24,107	28.1	$859	•
1981	28,398	28.6	993	15.6
1982	34,536	29.1	1,188	19.6
1983	39,214	29.6	1,325	11.6
1984	42,777	30.0	1,426	7.6
1985	45,925	30.6	1,501	5.3
Part B				
1980	$10,472	27.4	$382	•
1981	12,544	27.9	449	17.5
1982	14,731	28.4	518	15.5
1983	17,542	29.0	605	16.8
1984	19,769	29.4	672	11.0
1985	21,865	30.0	729	8.5

Source: HCFA data; benefit payments on an incurred basis.

We analyzed changes in (1) the cost of providing inpatient hospital care under part A and (2) the cost of all part B services. The cost of these services represented about 96 percent of total Medicare costs in fiscal year 1985. We also analyzed the cost of home health care under parts A and B, which accounted for an additional 2 percent of total Medicare costs.

Increase in Inpatient Care Cost for Medicare

The cost of providing inpatient general hospital care for Medicare beneficiaries increased from about $23.1 billion in fiscal year 1980 to about $43 billion in fiscal year 1985 (about 86 percent). The cost of providing inpatient hospital care, the number of days of care provided, the cost per day of care, and the growth rate in this cost for fiscal years 1981 through 1985 are shown in table 2.3, indicating that the total cost and cost per day both increased during the period.

Table 2.3: Cost of Inpatient Hospital Care Under Medicare Part A, Fiscal Years 1980 Through 1985

Fiscal year	Total benefit cost (millions)	Total covered days (millions)	Cost per covered day	Growth rate in cost per day (in percent)
1980	$23,129	110	$211	•
1981	27,161	112	242	14.8
1982	32,786	115	286	18.2
1983	37,040	116	319	11.5
1984	40,258	102	393	23.3
1985	43,008	88	489	24.4

Source: HCFA data; benefit payments on an incurred basis. Total covered days and cost per day for fiscal years 1984 and 1985 are current as of November 1986, but are still considered incomplete by HCFA.

The sharp increase in the cost per day of inpatient hospital care in fiscal years 1984 and 1985 is misleading since it was caused in part by the decreased number of days. We believe it is preferable to look at the cost of inpatient hospital care in terms of the cost per Medicare enrollee because this method takes into account the effect of decreased days of care as well as the increase in enrollees over time.

The total benefit cost of inpatient hospital care converted to 1985 dollars (using the consumer price index for hospital rooms), the number of enrollees, the cost per enrollee in 1985 dollars, and the growth rate in cost per enrollee in 1985 dollars for fiscal years 1970 through 1980 and 1981 through 1985 are shown in table 2.4.

Table 2.4: Cost of Inpatient Hospital Care Per Medicare Enrollee, Fiscal Years 1970 Through 1985 (In 1985 Dollars)

Fiscal year	Total benefit cost: 1985 dollars (millions)	Enrollees (millions)	Actual cost per enrollee: 1985 dollars	Growth rate in cost per enrollee (in percent)
1970	$22,786	20.4	$1,119	•
1971	23,328	20.7	1,125	0.5
1972[a]	24,257	21.1	1,149	2.1
1973[a]	25,412	21.6	1,178	2.5
1974[a]	27,898	23.9	1,166	−1.0
1975	29,777	24.6	1,208	3.6
1976	31,068	25.3	1,227	1.6
1977	34,230	26.1	1,312	6.9
1978	35,737	26.8	1,335	1.7
1979	36,793	27.5	1,340	0.4
1980	39,229	28.1	1,398	4.3
Average				2.3
1981	40,112	28.6	1,404	0.4
1982	41,844	29.1	1,439	2.6
1983	42,467	29.6	1,435	−0.3
1984	42,634	30.0	1,421	−1.0
1985	43,008	30.6	1,406	−1.1
Average				0.1

Source: Based on total benefit cost data provided by HCFA's Office the Actuary; costs are on an incurred basis.

[a]Mandatory price controls in effect.

As can be seen from table 2.4, the average inflation-adjusted growth rate in cost per enrollee for 1981 through 1985 (about 0.1 percent) was much lower than the average growth rate for fiscal years 1970 through 1980 (about 2.3 percent).[3] Had the average annual growth rate in cost per enrollee for fiscal years 1970 through 1980 continued through 1985, Medicare hospital costs would have been about $11.5 billion[4] more in constant 1985 dollars than they actually were.

Part of the reason for the slowdown in hospital benefit cost growth was the lower utilization of inpatient hospital services. The average Medicare beneficiary used about 26 percent fewer inpatient hospital days in fiscal year 1985 than he or she did in fiscal year 1980. The number of

[3]The difference in average growth rates for the two periods was statistically significant at the 90-percent confidence level.

[4]Had we used the medical component of the consumer price index as the deflator instead of the hospital room component, the estimated savings would have been about $10 billion.

hospital admissions, the admissions per 1,000 enrollees per year, the average covered days per admission, and the covered days of care per 1,000 enrollees per year for fiscal years 1980 through 1985 are shown in table 2.5.

Table 2.5: Inpatient Hospital Utilization Under Medicare

Fiscal year	Admissions (millions)	Admissions per 1,000 enrollees	Average covered days per admission	Covered days of care per 1,000 enrollees /year
1980	10.2	365	10.7	3,908
1981	10.7	374	10.5	3,926
1982	11.4	391	10.1	3,943
1983	11.8	400	9.8	3,926
1984	11.8	392	8.7	3,415
1985	11.2	365	7.9	2,875

Source: HCFA's Bureau of Data Management and Strategy; data for fiscal years 1984 and 1985 are current through November 1986, but are still considered incomplete by HCFA.

The number of admissions in fiscal year 1985 increased about 9 percent over fiscal year 1980, but the number of admissions per 1,000 enrollees was the same, and the average length of stay decreased 26 percent (which in turn decreased the covered days of care per 1,000 enrollees by about 26 percent), as shown in table 2.5. Thus, overall, Medicare enrollees used fewer hospital days in fiscal year 1985 than in fiscal year 1980.

We believe that legislative changes during the period could have played a key role in holding down the increase in hospital costs. For example, TEFRA established cost-per-case limits and a ceiling on the rate of increase in reimbursement to most hospitals. Under PPS, Medicare payments to hospitals were limited to amounts projected under the TEFRA provisions. Both the TEFRA limits and PPS provided hospitals incentives to reduce length of stay; we believe these changes in law have been responsible for a significant portion of the decrease in length of stay.

In addition, ORA provided that Medicare be the secondary payor in cases where the beneficiary has coverage under automobile, no-fault, or liability insurance. The four subsequent laws (see pp. 16-18) expanded this program making Medicare the secondary payor, as explained earlier. HCFA estimates that the Medicare secondary payor program saved Medicare about $460 million in fiscal year 1985.

Cost of Providing Medicare Part B Services

The total benefit costs for part B services increased about 109 percent from fiscal year 1980 through fiscal year 1985, from about $10.5 billion to about $21.9 billion; the cost per Medicare enrollee increased about 91 percent, from $382 to $729. The total benefit cost of providing part B services during fiscal years 1980 through 1985 is shown in table 2.6.

Table 2.6: Total Medicare Part B Benefit Costs

Fiscal year	Total benefit cost (millions)	Enrollees (millions)	Cost per enrollee	Growth rate in cost per enrollee (in percent)
1980	$10,472	27.4	$382	•
1981	12,544	27.9	449	17.5
1982	14,731	28.4	518	15.5
1983	17,542	29.0	605	16.8
1984	19,769	29.4	672	11.0
1985	21,865	30.0	729	8.5

Source: Based on total benefit cost data provided by HCFA's Office of the Actuary; costs are on an incurred basis.

As can be seen from table 2.6, the cost per enrollee increased at a relatively uniform rate from 1981 through 1983, but the growth rate began to decline in 1984 and 1985. Based on this decline, it appears that those 2 years were most affected by the legislative changes. The decline in growth rate for fiscal years 1984 and 1985 can be seen more clearly when the gr[illegible]th rate for those 2 years is compared with the rate for fiscal years [illegible]3 through 1983 (see table 2.7).

The total benefit cost of Medicare part B services converted to 1985 dollars (using the consumer price index for all medical services), the number of enrollees, the cost per enrollee in 1985 dollars, and the growth rate in cost per enrollee for fiscal years 1973 through 1983 and 1984 and 1985 are shown in table 2.7.

Table 2.7: Historical Cost Growth for Medicare Part B Services, Fiscal Years 1973 Through 1985

Fiscal year	Total benefit cost: 1985 dollars (millions)	Enrollees (millions)	Cost per enrollee	Growth rate in cost per enrollee (in percent)
1973	$7,535	20.9	$360	•
1974	8,614	23.2	372	3.2
1975	9,547	23.9	399	7.4
1976	10,645	24.6	432	8.3
1977	11,772	25.4	464	7.3
1978	12,846	26.1	493	6.1
1979	13,766	26.8	514	4.4
1980	15,854	27.4	579	12.5
1981	17,152	27.9	614	6.1
1982	18,004	28.4	634	3.2
1983	19,722	29.0	681	7.4
Average				6.6
1984	20,964	29.4	713	4.7
1985	21,865	30.0	729	2.3
Average				3.5

Source: Based on total benefit cost data provided by HCFA's Office of the Actuary; costs are on an incurred basis.

As can be seen from table 2.7, the inflation-adjusted average growth rate in part B cost per enrollee was about 6.6 percent for 1973 through 1983, but dropped to 3.5 percent for 1984 and 1985.[5] Had the average annual growth rate in part B cost per enrollee for 1973 through 1983 continued through 1985, Medicare part B costs would have been about $1.7 billion more (in constant 1985 dollars) than they actually were.

These results suggest that the legislative changes could have played a major role in reducing the rate of increase in the cost of Medicare part B services. For example, one of the most significant provisions of DEFRA, which affected part B cost outlays—the physician fee freeze—became effective in fiscal year 1984. In addition, most of the savings from a number of the TEFRA provisions relating to part B costs, such as the reduction in payments to radiologists and pathologists, were expected in fiscal years 1984 and 1985.

[5]Although the average growth rate was substantially lower in 1984 and 1985, the difference between the growth rate in those 2 years and 1973 through 1983 was not statistically significant at the 90-percent confidence level.

Cost of Home Health Care

Unlike the legislative changes for hospital and physician care, changes for home health care services were generally designed to expand benefits rather than to control the costs of these services. For example, section 930 of ORA expanded home health benefits under Medicare by providing for the coverage of an unlimited number of visits. Before this law, there was a limit of 100 visits during a benefit period. Section 930 also eliminated the requirement that a beneficiary be hospitalized 3 days before receiving home health services under part A. It is generally believed that home health care is less costly than care in hospitals or SNFs, and it appears that home health services were expanded in an effort to hold down total program costs.

The cost of providing home health care, the number of visits, the cost per visit, and the number of visits per 1,000 Medicare enrollees for fiscal years 1980 through 1985 (in constant 1985 dollars) are shown in table 2.8.

Table 2.8: Cost of Home Health Care (1985 Dollars), **Fiscal Years 1980 Through 1985**

Fiscal year	Total cost (millions)	Total visits (millions)	Cost per visit	Visits per 1,000 enrollees
1980	$960	22	$44	772
1981	1,087	24.8	44	855
1982	1,282	29.8	43	1,009
1983	1,525	36.2	42	1,204
1984	1,725	40.3	43	1,324
1985	1,664	40.1	42	1,289

Source: HCFA's Bureau of Data Management and Strategy; data for fiscal year 1985 are current through November 1986, but are still considered incomplete by HCFA.

Based on calculations from figures in table 2.8, we found the total cost of providing home health care increased about 73 percent (excluding inflation) from fiscal year 1980 through fiscal year 1985. The number of visits per 1,000 enrollees increased about 67 percent and reflects the increase in utilization of the home health benefit by Medicare enrollees. It is generally believed that the increase in the use of home health benefits is at least in part related to the shorter lengths of inpatient hospital stays (caused in part by PPS). The increased utilization, rather than higher costs per visit, accounted for most of the $704 million increase (in constant 1985 dollars) in total home health costs from fiscal year 1980 through fiscal year 1985.

Medicare Cost Reductions Under Gramm-Rudman-Hollings

The Balanced Budget and Emergency Deficit Control Act of 1985 (Public Law 99-177) was enacted on December 12, 1985. The law, commonly known as Gramm-Rudman-Hollings, sets up a series of budget targets under a process for eliminating the federal deficit by fiscal year 1991. Under the law, the Office of Management and Budget and CBO were to submit a joint report to the Comptroller General each year, estimating the amount by which federal expenditures exceed the legislative ceilings and the percentage reduction in each budget account necessary to achieve the desired spending levels. The Comptroller General was to reach judgement on the estimates provided and to issue a report to the President specifying actions needed to reduce the deficit through across-the-board reductions. The law required the President to then order the spending reductions the Comptroller General specified.

In a July 7, 1986, ruling, the Supreme Court declared the Comptroller General's role under the law unconstitutional because the Comptroller General is an officer of the legislative branch and, as such, may not carry out the executive functions assigned to him under the law. The reductions the President ordered for fiscal year 1986 were then invalidated. However, Public Law 99-366 reaffirmed the reductions under Gramm-Rudman-Hollings for fiscal year 1986.

Gramm-Rudman-Hollings provides that if across-the-board reductions are made, the reductions for the Medicare program are limited to reducing payment amounts for covered services by 1 percent in fiscal year 1986 and 2 percent for fiscal year 1987 and each subsequent year. Medicaid was exempted from reductions under this legislation. The appropriation amount, reduction amount, and the balance of funds for Medicare in fiscal year 1986 are shown in table 2.9. The amounts shown in the table do not include changes to the Medicare budget as a result of COBRA, mentioned above, which was enacted after the across-the-board reductions for fiscal year 1986; across-the-board reductions for fiscal year 1987 have not been made.

Table 2.9: Effect of Gramm-Rudman-Hollings on the Fiscal Year 1986 Medicare Budget

Dollars in thousands

Program activity	Baseline	Amount reduced[a]	Balance
Benefits			
Part A	$48,553,000	$230,000	$48,323,000
Part B	25,012,000	50,000	24,962,000
Program management			
Research (trust funds)	14,750	630	14,120
Research (general revenues)	16,000	688	15,312
Medicare contractors (trust funds)	978,500	42,076	936,424
State certification (trust funds)	48,434	2,083	46,351
Support contracts (general revenues)	3,250	140	3,110
End-Stage Renal Disease networks (trust funds)	4,837	208	4,629
HCFA administration (trust funds)	144,898	6,231	138,667
Non-HCFA administration (trust funds)	488,762	21,016	467,746
Federal administration (general revenues)	70,283	3,022	67,261
Peer review organizations (trust funds)	389,677	16,756	372,921
Total	**$75,724,391**	**$372,850**	**$75,351,541**

Source: HCFA's Office of Management and Budget.

[a]Amounts apply to Mar. 1, 1986, through Sept. 30, 1986.

Summary

Based on projections at the time of enactment, CBO and HCFA estimated that the five major laws passed during 1980 through 1986 would significantly reduce Medicare outlays through 1986. Our analysis of the cost of providing inpatient hospital care under part A and the cost of all part B services shows that there was a slowdown in Medicare cost growth during fiscal years 1981 through 1985 as compared with 1970 through 1980. We believe that these laws played a major role in this slowdown.

Effects of Five Major Laws on Medicaid Costs

The major Medicaid provisions in five major laws enacted from 1980 through 1986 had different purposes and, thus, were expected to have a mixed effect on Medicaid program costs. The laws enacted earlier in the period—primarily OBRA—encouraged states to cut Medicaid costs and, therefore, were expected to reduce total Medicaid outlays. Conversely, the laws enacted later in the period—primarily DEFRA—generally expanded eligibility for Medicaid services, and were expected to increase total Medicaid outlays. Overall, CBO estimated that the net effect of the major laws enacted during 1980 through 1986 would be a reduction in Medicaid costs of $3.9 billion; HCFA estimated a reduction of $1.8 billion.

Neither CBO nor HCFA has retrospectively analyzed the actual effects of these laws on Medicaid costs, and we did not attempt such an analysis because of the lack of comparable data from year to year. It appears, nevertheless, from total Medicaid cost experience that program cost growth generally was affected as CBO and HCFA projected—a sharp decline in the rate of cost growth in fiscal year 1982 with increases in 1983 and 1985 which, however, were lower than the historical cost growth.

Estimated Effects of Five Major Laws on Medicaid

Although each of the five major laws was expected to reduce Medicare cost outlays (see ch. 2), this was not the case with Medicaid. CBO and HCFA estimated that only two of the five major laws passed during 1980 through 1986 would result in Medicaid savings; the other three would increase program costs. The estimated cost effect, based on CBO and HCFA projections, of each of the five laws, is shown in table 3.1.

Table 3.1: Estimated Cost Effects of Five Major Laws on Medicaid Costs, Fiscal Years 1981 Through 1986

Dollars in millions

		Cumulative effect on costs: fiscal years 1981 through 1986	
Major law	**Date passed**	**CBO**	**HCFA**
ORA	Dec. 5, 1980	$8	$3
OBRA	Aug. 13, 1981	−2,885	−1,166
TEFRA	Sept. 3, 1982	−1,141	−1,072
DEFRA	July 18, 1984	118	373
COBRA	Apr. 7, 1986	36	62
Total		**−$3,864**	**−$1,800**

As can be seen from table 3.1, CBO estimated that, overall, the five laws would reduce Medicaid costs by $3.9 billion; HCFA estimated $1.8 billion.

Most of the savings were expected to come from OBRA. The major savings provision of this law specified that federal matching funds to each state would be reduced by 3 percent in fiscal year 1982, 4 percent in 1983, and 4.5 percent in 1984. A state could, however, lower the amount of the reduction by operating a qualified hospital cost review program, having an unemployment rate higher than the national average, or recovering a specified amount of unauthorized expenditures from providers. In addition, a state was entitled to a dollar for dollar offset in its reduction if total federal Medicaid expenditures in a year fell below a specified target amount. Thus, OBRA encouraged states to increase the efficiency of their program administration and to reduce the rate of growth in Medicaid costs. CBO did not make estimates of the effects of OBRA's individual provisions on Medicaid costs.

Actual Effects of Five Major Laws Not Measured

Again, neither CBO nor HCFA analyzed the actual effects of the legislative changes on the cost of providing Medicaid services. The actual Medicaid cost data show that the rate of Medicaid cost growth decreased in fiscal year 1982, but was increasing again by 1985. The Medicaid cost growth rate was generally consistent with the projected effects of the five major laws during 1981 through 1986.

We did not attempt to determine what the cost of the Medicaid program would have been during fiscal years 1981 through 1985 if there had been no legislative changes because we did not believe that data from 1970 through 1980 would provide a good basis for a meaningful analysis. Specifically, the data from fiscal years 1970 through 1980 was not comparable from year to year because of changes in

- the number of states having a Medicaid program,
- the groups covered by Medicaid, and
- the types of health services paid for by the programs in the various states.

Increase in Medicaid Payment Cost

During fiscal year 1973 through fiscal year 1985, total Medicaid payment cost (federal and state) grew about 334 percent, from $8.6 billion to $37.5 billion. The total Medicaid program payment cost from fiscal year 1973 through fiscal year 1985 in actual dollars, in constant 1985 dollars, and the annual growth rate for both are shown in table 3.2.

Table 3.2: Total Medicaid Payment Cost, Fiscal Years 1973 Through 1985

Fiscal year	Total payment cost: actual dollars (millions)	Growth rate (in percent)	Total payment cost: 1985 dollars (millions)	Growth rate (in percent)
1973	$8,640	•	$26,052	•
1974	9,983	15.5	27,301	4.8
1975	12,292	23.1	29,862	9.4
1976	14,135	15.0	31,203	4.5
1977	16,277	15.2	32,682	4.7
1978	17,966	10.4	33,207	1.6
1979	20,474	14.0	34,488	3.9
1980	23,301	13.8	35,276	2.3
1981	27,204	16.8	37,198	5.4
1982	29,399	8.1	35,931	−3.4
1983	32,391	10.2	36,417	1.4
1984	33,891	4.6	35,939	−1.3
1985	37,522	10.7	37,522	4.4

Source: Medicare and Medicaid Data Book, 1983; and HCFA's Office of the Actuary. We converted the actual total payment cost to constant 1985 dollars using the consumer price index for all medical services.

Total Medicaid payment costs (actual dollars) grew at an average annual rate of about 15 percent from fiscal year 1973 through fiscal year 1981. In fiscal year 1982, however, the cost growth rate—in both actual and constant dollars—dropped sharply. The 1982 decline in Medicaid cost growth was the result of state cost-cutting actions undertaken in part to reverse the adverse effects of the double-digit cost growth on their state budgets. In addition, OBRA provided states an incentive to hold down their program costs as a way of minimizing the reductions in federal matching funds mandated by this law.

As part of an effort to control program costs, states reduced or limited benefits, eligibility, and provider reimbursement. For example, according to a 50-state survey by the Intergovernmental Health Policy Project and State Medicaid Information Center, in 1982:

- 11 states limited the use of hospital inpatient services;
- 13 states reduced the amount, scope, and duration of covered services or restricted coverage of services (primarily for prescription drugs);
- 14 states imposed or increased copayments on optional services, primarily prescription drugs;

- 19 states adopted proposals to limit or decrease hospital reimbursement; and
- 16 states limited or decreased physician reimbursement.

In total, 30 states took some action to reduce or limit benefits, eligibility, or provider reimbursement in 1981, and the same number did so in 1982.

In contrast to the 1981 and 1982 period of contraction, the trend among states from 1983 through 1985 was to expand somewhat program eligibility and services. Fifteen states adopted expansions in 1983, and 19 states did so in 1984. DEFRA also required states to provide Medicaid coverage to certain pregnant women and children meeting the income and resource criteria for the Aid to Families with Dependent Children program. In 1985, 28 states adopted policies that expanded program eligibility—12 of them to comply with expanded coverage requirements of DEFRA.

Summary

CBO and HCFA projected that the five major laws enacted from 1980 through 1986 would have a mixed effect on Medicaid costs—two of the five laws were expected to result in savings; the other three were expected to increase program costs. The actual program cost experience has generally been consistent with these projections.

Chapter 4

Beneficiary Out-of-Pocket Costs Have Increased

Beneficiaries share in the cost of their health care expenses under Medicare and, to a lesser extent, under Medicaid. Our analysis shows that the average out-of-pocket cost per enrollee for Medicare part A services, in constant 1985 dollars, increased about 49 percent from $84 in 1980 to $125 in 1985. The average out-of-pocket cost per part B enrollee in 1985 dollars increased about 31 percent during the same period, from $395 to $516. We believe that most of the increase in beneficiary costs under parts A and B can be attributed to the five major laws enacted during the period.

TEFRA generally expanded Medicaid cost-sharing options available to the states and, as of December 1985, 26 states took 34 policy actions to either adopt or expand a program where Medicaid recipients share in the cost of their health services. However, the varying state cost-sharing requirements and nonavailability of state data precluded an analysis, on a national basis, of the change in out-of-pocket costs of Medicaid recipients.

Beneficiary Costs Under Medicare

Under Medicare, beneficiaries pay a deductible for inpatient hospital services which, until 1987, was based on the average cost of 1 day of hospitalization.[1] A deductible is paid for each benefit period, which begins with a hospitalization and ends when the beneficiary has not been in a hospital or SNF for 60 consecutive days. In 1980, the deductible was $180, but in 1987 it had increased to $520. For extended hospital stays, beneficiaries are required to pay a coinsurance amount equal to one-fourth of the deductible per day ($130 per day in 1987) for the 61st through the 90th day. For stays greater than 90 days, beneficiaries have 60 lifetime reserve days during which they pay a coinsurance amount equal to one-half of the deductible per day ($260 per day in 1987). Beneficiaries who have exhausted their lifetime reserve days are liable for the entire cost of hospital services provided beyond the 90th day.

Medicare pays the full cost of the first 20 days of SNF care after beneficiaries are discharged from a hospital. Beneficiaries pay a coinsurance amount equal to one-eighth of the hospital deductible ($65 in 1987) for the 21st through the 100th day, and are responsible for the entire cost of SNF care provided after the 100th day. In addition, aged persons who

[1] After 1987 the deductible amount will be computed by multiplying the prior year's deductible by the percentage increase in PPS payment rates.

are not eligible for Social Security and thus not eligible for part A coverage under Medicare can enroll voluntarily by paying a monthly premium. In fiscal year 1985, about 18,200 people enrolled and paid a monthly premium of $174 each. The monthly premium will be $226 in 1987.

Although coverage under part B of Medicare is voluntary, nearly everyone participating in part A also elects to participate in part B. Enrollees under part B are required to pay a monthly premium ($17.90 in 1987), which establishes coverage. Users of part B services must pay an annual deductible of $75 ($60 prior to 1982). Under part B, the beneficiary is responsible for paying 20 percent of the Medicare-determined reasonable charge on claims where the physician or supplier has accepted assignment. For unassigned claims, the beneficiary is also liable for the difference between what the physician or supplier charges and what Medicare allows as the reasonable charge.

We estimated average out-of-pocket costs per enrollee under Medicare parts A and B for 1980 and 1985. The results of our analysis are shown in table 4.1.

Table 4.1: 1980 and 1985 Average Beneficiary Out-of-Pocket Costs

Dollars in millions

	1980 cost	1980 cost in 1985 dollars	1985 cost
Part A			
Deductible	$1,395	$1,821	$3,092
Coinsurance (hospital)	312	407	485
Coinsurance (skilled nursing facility)	100	131	257
Total	**$1,807**	**$2,359**	**$3,834**
Average cost per enrollee	$64[a]	$84[a]	$125[b]
Part B			
Deductible	$1,208	$1,577	$1,787
Coinsurance	2,535	3,309	5,480
Premiums	3,011	3,931	5,613
Reasonable charge reductions, unassigned claims	1,538	2,008	2,603
Total	**$8,292**	**$10,825**	**$15,483**
Average cost per enrollee	$303[c]	$395[c]	$516[d]

Source: HCFA data; costs are for calendar years. We converted the 1980 costs to 1985 dollars by using the consumer price index.

[a]For 28.1 million enrollees.

[b]For 30.6 million enrollees.

[c]For 27.4 million enrollees.

[d]For 30 million enrollees.

As can be seen from table 4.1, with the effects of inflation removed, there was an increase in the total amount beneficiaries paid for coinsurance for inpatient hospital stays, SNF care, and inpatient hospital deductibles. This caused the 1985 constant dollar average cost per Medicare part A enrollee to increase from $84 in 1980 to $125 in 1985, an increase of about 49 percent.

The changes in the total part A deductible and coinsurance amounts paid by Medicare beneficiaries were caused in part by legislative changes. Section 1813(b)(2) of the Social Security Act requires the Secretary of HHS to determine, each year, the amount of the hospital deductible. The deductible is derived through a mathematical formula, and the coinsurance amounts for inpatient hospital and SNF care are specified fractions of the inpatient hospital deductible amount.

OBRA raised the base used in the formula for determining the part A deductible, and thus increased the deductible and coinsurance amounts

for each year beginning with calendar year 1982.[2] The reduction in average hospital length of stay also contributed to an increase in the deductible amount. The deductible and coinsurance amounts for 1980 through 1987 are shown in table 4.2.

Table 4.2: Deductible and Coinsurance Amounts Under Medicare Part A, 1980 Through 1987

	Inpatient hospital			Nursing home
Benefit period	Deductible	Daily coinsurance: 61st through 90th day	Daily coinsurance: 60 lifetime reserve days	Daily coinsurance: 21st through 100th day
1980	$180	$45	$ 90	$ 22.50
1981	204	51	102	25.50
1982	260	65	130	32.50
1983	304	76	152	38.00
1984	356	89	178	44.50
1985	400	100	200	50.00
1986	492	123	246	61.50
1987	520	130	260	65.00

Source: HCFA's Office of Beneficiary Services.

Thus, the increasing rates during the period were primarily responsible for the after-inflation increase in the total amount paid for part A deductibles (from $1.8 billion in 1980 to $3.1 billion in 1985) and coinsurance for SNF care (from $131 million to $257 million). The increasing deductible also helped increase the total amount paid for inpatient hospital coinsurance from $407 million in 1980 (adjusted for inflation) to $485 million in 1985.

In addition, OBRA changed the basis for determining the coinsurance for inpatient hospital services. This act based the coinsurance amount on the deductible for the calendar year in which services are received rather than on the deductible in effect at the time the beneficiary's illness began.

The inflation-adjusted beneficiary out-of-pocket cost per capita for part B services increased from $395 in 1980 to $516 in 1985, about 31 percent. Increases in the total amounts paid for deductibles, coinsurance, premiums, and reasonable charge reductions on unassigned claims were due in part to the legislative changes enacted during the period. ORA provided that the determination of Medicare reasonable charges for physician services be based on the date the service was rendered rather than

[2]The Omnibus Budget Reconciliation Act of 1986 (Public Law 99-509) again changed the way the deductible will be computed beginning in January 1987 (see footnote 1).

the date on which the claim was processed. This change reduced program costs, but it increased beneficiaries' costs on unassigned claims. OBRA increased the part B deductible from $60 to $75 beginning in 1982.

TEFRA changed the calculation of the part B premium for two 1-year periods beginning in July 1983. This change allowed part B premiums to increase to an amount equal to 25 percent of projected part B costs. PPS extended the period through December 1985, and DEFRA extended it through 1987. Because of this change in the calculation of premiums, in 1986, beneficiaries paid about $650 million more (about $22 more per beneficiary per year) than if there had been no change. The premium amounts for 1980 through 1987 are shown in table 4.3.

Table 4.3: Premium Amounts Under Medicare Part B

Benefit period	Premium amount
1980	$9.60
1981	11.00
1982	12.20
1983	12.20
1984	14.60
1985	15.50
1986	15.50
1987	17.90

Source: HCFA data.

Total beneficiary liability for reasonable charge reductions increased from $2 billion in 1980 to about $2.6 billion in 1985 (in constant 1985 dollars). However, the amount of beneficiary liability for reasonable charge reductions decreased between 1984 and 1985 because of the increased assignment rate. In general, as more physicians accept assignment, out-of-pocket costs to beneficiaries decrease because they have no liability for reasonable charge reductions on assigned claims (see p. 35). DEFRA provided incentives to encourage physicians to accept assignment on all Medicare claims. Other factors, such as the increased supply of physicians, may also have increased the assignment rate. Medicare's national assignment rate hit a low of about 48 percent in 1976, and then it began to increase. In fiscal year 1980, the assignment rate was about 52 percent; by fiscal year 1984, it was 58 percent; it increased to 69 percent in fiscal year 1985. In effect, the increase in the assignment rate between 1980 and 1985 meant that beneficiaries were liable for about $1.6 billion less in reasonable charge reductions on unassigned claims than if the assignment rate had remained at the 1980 level.

Our analysis shows the general change in Medicare beneficiary out-of-pocket costs between 1980 and 1985. There are a number of qualifications, however, about the figures used that should be considered. First, the costs per enrollee shown are average costs for all enrollees. The actual cost to an individual beneficiary will vary depending on the kind and amount of services received. For example, in 1985 only about 25 percent of part A enrollees were hospitalized. Because the 1985 deductible for inpatient hospital services alone was $400, the out-of-pocket costs for beneficiaries who were hospitalized was much higher than the estimated average cost of $125 shown. Conversely, the beneficiaries who were not hospitalized had no out-of-pocket costs (deductibles or coinsurance) for inpatient hospital services.

In addition, the out-of-pocket costs shown in our analysis do not reflect beneficiary payments for services and health needs not covered by Medicare, such as long-term care in SNFs, dental care, prescription drugs, and hearing aids. In 1980, claims totaling about $508 million were denied because they were for noncovered services. This amount rose to $830 million in 1985.[3] However, most beneficiaries probably do not submit claims for services that are not covered, and we could find no data on the total amount Medicare beneficiaries spend for noncovered services.

The out-of-pocket costs for medical services for some beneficiaries (CBO estimates about 72 percent) is also affected by private health insurance—the most common form is called Medigap insurance. For those beneficiaries that have Medigap policies, out-of-pocket costs are increased by the amount of the premiums and decreased by the benefits paid, which usually cover the Medicare deductible and coinsurance amounts. In a recent report,[4] GAO estimated that premiums for Medigap insurance in 1984 totalled about $5 billion. Medigap policies sold to individuals must have anticipated benefits for policyholders of at least 60 percent of premiums collected; for policies sold to groups, at least 75 percent of premiums collected.

Based on the policies reviewed, GAO concluded that Medigap policies sold by (1) commercial insurers that had more than $50 million in earned premiums and (2) Blue Cross/Blue Shield plans generally met these benefit payout requirements. However, over 60 percent of the commercial

[3]Amounts shown do not reflect amounts subsequently awarded as a result of a review or hearing.

[4]Medigap Insurance: Law Has Increased Protection Against Substandard and Overpriced Policies (GAO/HRD-87-8, Oct. 17, 1986).

insurance policies with earned premiums under $50 million in 1984 had actual benefit payments below these percentages. Medigap insurance added to beneficiary out-of-pocket expenses because, on average, premium costs were greater than benefits paid.

Finally, about 11 percent of Medicare enrollees are also covered under Medicaid. The direct cost per capita to dual beneficiaries are less than the cost to the general Medicare population because Medicaid generally pays dual beneficiaries' coinsurance, deductible, and premium amounts.

Beneficiary Costs Under Medicaid

Medicaid is administered independently by each state, within broad federal guidelines. The states have the flexibility to establish income and resource eligibility levels; the scope, amount, and duration of services; methods and levels of reimbursement; and administrative structure. As a result, Medicaid varies from state to state, including the cost-sharing requirements for Medicaid recipients.

The Medicaid program was established for people who are unable to pay for health care. The original Medicaid legislation, enacted in 1965, prohibited the imposition of any cost-sharing for inpatient hospital services for all Medicaid eligibles. Cost-sharing for other services was permitted, but was based on the recipient's income and resources. This relationship to income and resources, in effect, totally exempted the categorically needy from all Medicaid cost-sharing since their eligibility for one of the cash assistance programs—and thus for Medicaid—was conditioned on their lack of income and resources.

The 1972 amendments to the Social Security Act changed the Medicaid cost-sharing requirements, allowing states to impose nominal copayments on the categorically needy for optional services. TEFRA, enacted September 3, 1982, further expanded state cost-sharing options. With certain exceptions, states can now require copayments, coinsurance, and deductibles for almost all services—mandatory as well as optional—for both the categorically and medically needy.

Under TEFRA, cost-sharing was to remain nominal. For example, deductibles cannot exceed $2 per month per family for each period of eligibility; coinsurance rates cannot exceed 5 percent of the payment the state makes for the service; and maximum copayments for noninstitutional services range from $.50 to $3, depending on the amount of the state payment for the service.

Since TEFRA, states have generally expanded their cost-sharing requirements. Surveys of state Medicaid programs by the Intergovernmental Health Policy Project and the National Governors' Association show that, during September 1982 to December 1985, 26 states took 34 policy actions to either adopt a copayment program or expand an existing program, while 13 states dropped or relaxed copayment programs. As of December 1985, 28 states and the District of Columbia had copayment programs, while 22 states did not.

Among states that have cost-sharing programs, there is a wide variation in the services and procedures on which copayments are imposed. For example, Maine requires a copayment only on prescription drugs; Iowa has copayment requirements on 12 types of health services, including podiatrist, optometrist, dental, medical equipment, hearing aids, and physical therapy. Some of the more common services for which copayments are imposed include prescription drugs, hearing aids, dental care, and hospital emergency room services for nonemergency health care.

Only three states with cost-sharing programs have coinsurance provisions. Florida Medicaid recipients must pay 5 percent of the cost of dentures and hearing aids; Missouri recipients must pay for dental care 5 percent of whichever is less—allowable Medicaid reimbursement or provider's billed charges. South Dakota charges 5 percent of allowable reimbursement for prosthetic devices, medical equipment, and mental health center services.

Medicaid beneficiaries can incur substantial out-of-pocket costs when they are institutionalized in a nursing home. These beneficiaries are required to apply all of their income[5] to the cost of their care except for a personal needs allowance (for example, $25 a month in Georgia and $35 a month in Maryland). Thus, if the cost of a Georgia beneficiary's nursing home care was $1,200 per month, and he or she received Social Security benefits of $500 per month, $475 would be applied to the cost of care; the beneficiary would retain $25 as a personal needs allowance, and Medicaid would pay the nursing home $725 and pay for any other covered services the beneficiary received.

However, Medicaid recipients' use of personal income to offset some of the cost of nursing home care is not strictly comparable with the out-of-pocket medical expenses for noninstitutionalized Medicaid and Medicare

[5]If the beneficiary has a spouse who is not institutionalized, a portion of the beneficiary's income is provided for the spouse's maintenance.

beneficiaries. As out-of-pocket costs for medical services increase, noninstitutionalized beneficiaries generally have less to spend on their other needs. This is not a problem, however, with Medicaid recipients living in nursing homes because their basic needs (e.g., room and board) are furnished by the nursing home.

Summary

From 1980 through 1985, Medicare beneficiary average out-of-pocket costs (adjusted for inflation) have increased about 49 percent for part A services and about 31 percent for part B services. We believe that most of the increase can be attributed to major legislation enacted during the period.

We could not measure the change in Medicaid recipient out-of-pocket costs. However, many states have expanded their cost-sharing requirements for Medicaid recipients since the enactment of TEFRA.

Chapter 5

Increase in Medicare Providers and Use of Services

The number of providers participating in Medicare increased about 31 percent from 1980 through 1985. The greatest increase was in the number of home health agencies (HHAs). The number of licensed physicians increased nationwide from 365,000 in 1980 to 425,000 in 1985. HCFA does not have information on the number of physicians that actually treat Medicare beneficiaries.

The use rate of many types of Medicare services also increased during 1980 through 1985. A major exception to this trend was in the number of covered days of care in hospitals, which decreased about 26 percent.

Increase in Medicare Providers

Under Medicare, providers are defined as the following: hospitals, SNFs, HHAs, hospices, and comprehensive outpatient rehabilitation and outpatient physical therapy (including speech pathology) facilities. During 1980 through 1985, there was an increase in the number of all types of health care providers participating in the Medicare program, except for inpatient hospitals, which decreased by about 1 percent. The number and type of providers participating in Medicare in 1980 and 1985 are shown in table 5.1.

Table 5.1: Number of Providers Participating in Medicare, 1980 and 1985

Type of facility	Participating as of June 1980	Participating as of June 1985	Difference between 1980 and 1985	Growth rate (in percent)
Hospitals	6,777	6,707	−70	−1.0
SNFs	5,052	6,451	1,399	27.7
HHAs	2,924	5,679	2,755	94.2
Hospices	[a]	164	164	•
Comprehensive outpatient rehabilitation facilities	[b]	72	72	•
Outpatient physical therapy[c]	419	854	435	103.8

Source: HCFA's Bureau of Data Management and Strategy.

[a]Coverage was effective on 11/83.

[b]Coverage was effective on 7/81.

[c]Includes speech pathology.

Although not included in the Medicare definition of provider, we also attempted to gather data on the number of other types of facilities that furnished services under Medicare in 1980 and 1985 (see table 5.2).

Table 5.2: Other Facilities Furnishing Services Under Medicare, 1980 and 1985

Type of facility	Participating as of June 1980	1985	Difference between 1980 and 1985	Growth rate (in percent)
Independent laboratories[a]	3,663	4,288	625	17.1
End stage renal disease facilities	999	1,393	394	39.4
Rural health clinics	391	428	37	9.5
Ambulatory surgical centers	[b]	336	336	•

Source: HCFA's Bureau of Data Management and Strategy.

[a]Includes portable X-ray.

[b]Coverage was effective on 9/82.

Under Medicare, any licensed physician, unless specifically excluded,[1] can participate in the program and receive payment for treating beneficiaries. Nationally, there were 365,000 licensed physicians in 1980 and 425,000 in 1985. HCFA does not maintain information on the number of physicians who actually treat Medicare beneficiaries.

Since October 1, 1984, Medicare has had a "participating physician" program, under which physicians can agree on a year-to-year basis to accept assignment on all Medicare claims. Nonparticipating physicians may accept or reject assignment on a claim-by-claim basis, as all physicians treating Medicare patients did before the participating physician program was introduced. As incentives to participate, DEFRA provided for periodic publication of lists of participating physicians and electronic claims processing for them. The number of participating physicians in Medicare increased from 118,428 in fiscal year 1985 to 120,531 by December 1986.

Increase in Use of Medicare Services

The use of many types of Medicare services increased during the period 1980 through 1985, as shown in table 5.3.

[1]Physicians convicted of Medicare-related or Medicaid-related crimes are automatically excluded. Physicians can also be excluded if HHS determines that they have (1) submitted fraudulent claims, (2) habitually overutilized or otherwise abused the Medicare program, or (3) failed to provide care of a quality meeting professionally recognized standards of health care.

Table 5.3: Beneficiary Use of Medicare Services, 1980 and 1985

	Use rate per 1,000 enrollees	
	Fiscal year	
Type of service	**1980**	**1985[a]**
Covered days of care, inpatient hospital	3,908	2,875
Covered days of care, SNF	309	280
Visits, HHA	772	1,292
	Calendar year	
	1980	**1985[b]**
Outpatient hospital services	275	348
Physician and other medical services	630	686

Source: HCFA's Bureau of Data Management and Strategy.

[a]Current as of November 1986, but still considered incomplete by HCFA.

[b]Data for 1985 were not available; figures shown are GAO projections based on the average increase in use for 1980 through 1984.

As can be seen from table 5.3, the use of HHA, outpatient hospital, and physician and other medical services increased during the period, while the number of inpatient hospital and SNF days decreased.

Appendix I

Public Laws Changing Medicare and Medicaid (Mar. 1980 to Oct. 1986)

Public law	Title	Date
96-212	Refugee Act of 1980	Mar. 17, 1980
96-265	Social Security Disability Amendments of 1980	June 9, 1980
96-272	Adoption Assistance and Child Welfare Act of 1980	June 17, 1980
96-369	Funding of Abortions	Oct. 1, 1980
96-422	Refugee Education Assistance Act of 1980	Oct. 10, 1980
96-473	Status of Applications in Regard to Medicare Entitlement	Oct. 19, 1980
96-499	Omnibus Reconciliation Act of 1980	Dec. 5, 1980
97-12	Funding of Abortions, Resettlement of Refugees	June 5, 1981
97-34	Economic Recovery Tax Act of 1981	Aug. 13, 1981
97-35	Omnibus Budget Reconciliation Act of 1981	Aug. 13, 1981
97-51	Funding of HHS Activities	Oct. 1, 1981
97-85	Funding of HHS Activities	Nov. 23, 1981
97-92	Funding of HHS Activities	Dec. 15, 1981
97-248	Tax Equity and Fiscal Responsibility Act of 1982	Sept. 3, 1982
97-276	Funding of HHS Activities	Oct. 2, 1982
97-377	Funding of HHS Activities	Dec. 21, 1982
97-414	Orphan Drug Act	Jan. 4, 1983
97-448	Technical Corrections Act of 1982	Jan. 12, 1983
98-8	Funding—Home Health Services	Mar. 4, 1983
98-21	Social Security Amendments of 1983	Apr. 20, 1983
98-94	DOD Authorization Act of 1984	Sept. 24, 1983
98-107	Funding for Health Planning	Oct. 1, 1983
98-139	Appropriations Act for Labor, HHS, Education & Related Agencies Act, 1984	Oct. 31, 1983
98-151	Funding for Health Planning and Refugee Assistance	Nov. 14, 1983
98-369	Deficit Reduction Act of 1984	July 18, 1984
98-460	Social Security Disability Benefits Reform Act of 1984	Oct. 9, 1984
98-473	Funding of HHS Activities	Oct. 12, 1984
98-527	Developmental Disabilities Act of 1984	Oct. 19, 1984
98-619	Appropriation Act for Labor, HHS and related agencies	Nov. 9, 1984
99-107	Emergency Extension Act of 1985	Sept. 30, 1985
99-177	Balanced Budget and Emergency Deficit Control Act of 1985	Dec. 12, 1985
99-272	Consolidated Omnibus Budget Reconciliation Act of 1985	Apr. 7, 1986
99-509	Omnibus Budget Reconciliation Act of 1986	Oct. 21, 1986

Health Care Financing Administration's Estimates of Five Major Laws' Effects on Medicare Costs

Table II.1: Effects of ORA

Dollars in millions

Section	Part A provisions	Effective date	Fiscal years 1981	1982	1983	1984	1985
901	Nonprofit hospital philanthropy	On enactment	[a]	[a]	[a]	[a]	[a]
902	Reimbursement for inappropriate inpatient hospital services	July 1, 1981	[a]	$−35	$−40	$−45	$−55
904	Hospital providers of long-term care services	July 1, 1981	[a]	[a]	[a]	[a]	[a]
914	Coordinated audits under the Social Security Act	Apr. 1, 1981	$−4	−4	−4	−4	−4
918	Reimbursement of clinical laboratories	Apr. 1, 1981	−14	−22	−26	−29	−34
Section	**Part B provisions**						
930	HHA services:	July 1, 1981					
	Remove 100 visit limit		[a]	5	7	8	10
	Remove 3-day prior hospitalization stay requirement		2	12	13	15	16
	Remove HHA under part B from $60 deductible requirement		[a]	[a]	[a]	[a]	[a]
	Occupational therapy included as qualifying service		4	35	41	46	52
	Remove licensure requirement for proprietary HHA		[a]	[a]	5	10	15
931	Alcohol detoxification facility services	Apr. 1, 1981	40	70	90	110	120
932	Preadmission diagnostic testing	On enactment	[a]	[a]	[a]	[a]	[a]
933	Comprehensive outpatient rehabilitation facility services	July 1, 1981	5	13	15	17	20
934	Outpatient surgery	On enactment	0	−1	−4	−6	−9
936	Dentists' services	July 1, 1981	$2	$17	$19	$22	$25
937	Optometrists' services	July 1, 1981	0	2	2	3	3
938	Antigens	Jan. 1, 1981	[a]	[a]	[a]	[a]	[a]
939	Treatment of planter warts	July 1, 1981	0	2	2	2	2
941	Presumed coverage provisions	Jan. 1, 1981	0	0	0	0	0
942	Payment to providers of services	On enactment	−5	−7	−9	−10	−12
943	Limitation on payments to radiologists and pathologists	July 1, 1981	0	−14	−20	−26	−30
944	Physician treatment plan for speech pathology	Jan. 1, 1981	0	0	0	0	0
945	Reenrollment and open enrollment in part B	Apr. 1, 1981	2	16	18	20	23
946	Determination of reasonable charge	July 1, 1981	−157	−226	−231	−250	−279
947	Shortened part B termination period for certain individuals whose premiums Medicaid has ceased to pay	Apr. 1, 1981	0	0	0	0	0

Section	Part B provisions	Effective date	Fiscal years 1981	1982	1983	1984	1985
948	Reimbursement of physicians' services in teaching hospitals	Jan. 1, 1981	[a]	[a]	[a]	[a]	[a]
950	Hospital transfer requirement for SNF coverage	On enactment	[a]	[a]	[a]	[a]	[a]
953	Medicare liability secondary where payment can be made under liability or no fault insurance	On enactment	$0	$0	$−25	$−39	$−45
954	Payment for physicians' service where beneficiary has died	Jan. 1, 1981	0	0	0	0	0
956	Payment where beneficiary not at fault	Jan. 1, 1981	[a]	[a]	[a]	[a]	[a]
957	Technical renal disease amendments	On enactment	[a]	[a]	[a]	[a]	[a]
959	Temporary delay in periodic interim payments	Sept. 1981	[a]	[a]	[b]	[b]	[b]

Source: HCFA's Office of the Actuary.

[a]Negligible, not available, or indeterminate.

[b]Not applicable.

Table II.2: Effects of OBRA

Dollars in millions

Section		Effective date	Fiscal years 1981	1982	1983	1984	1985
2101	Payments to promote closing and conversion of underutilized facilities	Oct. 1, 1981	[a]	[a]	[a]	[a]	[a]
2102	Adjustment in payment for inappropriate hospital services	Sept. 1, 1981	$−10	$−10	$−10	$−15	$−20
2121	Elimination of part A coverage of alcohol detoxification facility services	Aug. 23, 1981	−70	−90	−110	−120	−130
2122	Elimination of need for occupational therapy as a basis for initial entitlement to home health services	Dec. 1, 1982	−35	−41	−46	−52	−58
2133	Deletion of part B deductible carryover provision	Jan. 1, 1982	−55	−55	−55	−55	−55
2134	Increase in part B deductible	Jan. 1, 1982	−120	−210	−240	−250	−260
2141	Limitation on cost differentials	Oct. 1, 1981	−100	−125	−155	−190	−235
2142	Limitation on reasonable cost and reasonable charge for outpatient services	On enactment	[a]	[a]	[a]	[a]	[a]
2146	Medicare payments secondary in cases of end-stage renal disease	Jan. 1, 1982	[a]	[a]	[a]	[a]	[a]
2151	Elimination of unlimited open enrollment	Oct. 1, 1981	−3	−10	−11	−13	−14
2155	Elimination of temporary delay in periodic interim payments	On enactment	$ −522	[b]	[b]	[b]	[b]

Source: HCFA's Office of the Actuary

[a]Negligible, not available, or indeterminate po

[b]Not applicable

Table II.3: Effects of TEFRA

Dollars in millions

Section	Part A provisions	Effective date	Fiscal years 1983	1984	1985	1986
101	Payment for inpatient hospital services	Oct. 1, 1982	$−405	$−1,240	$−2,490	$−3,640
102	Single reimbursement limits for SNF	Oct. 1, 1982	−15	−40	−40	−45
103	Elimination of the nursing salary cost differential	Oct. 1, 1982	−93	−115	−128	−144
105	Single reimbursement limits for HHAs	Oct. 1, 1982	−3	−6	−6	−7
106	Prohibiting payment for Hill-Burton free care	On enactment	[b]	[b]	[b]	[b]
107	Prohibiting payment for anti-unionization activities	On enactment	[a]	[a]	[a]	[a]
108	Reimbursement of provider-based physicians	Oct. 1, 1982	235	320	380	430
109	Prohibiting recognition of payments under percentage arrangements	On enactment	[a]	[a]	[a]	[a]
110	Eliminating "lesser of cost or charges" provision	When HHS specifies to the Congress	[a]	[a]	[a]	[a]
111	Elimination of private room subsidy	Oct. 1, 1982	[a]	[a]	[a]	[a]
114	Health maintenance organizations and other competitive medical plans	Sept. 30, 1982	0	0	0	0
116	Medicare payments secondary for working aged	Jan. 1, 1983	−145	−260	−300	−335
117	Interest charges on overpayments and underpayments	On enactment	[a]	[a]	[a]	[a]
119	Private sector review initiative	On enactment	−267	−322	−377	−437
120	Temporary delay in periodic interim payments	Sept. 1983 and Sept. 1984	−750	−100	870	0
121	Medicare coverage of federal employees	Jan. 1, 1983	$25	$50	$75	$105
122	Hospice care	Nov. 1, 1983	0	70	110	140
123	Coverage of SNF services without regard to 3-day prior hospitalization requirement	[c]	[a]	[a]	[a]	[a]
126	Extending Medicare proficiency examination authority	On enactment	[a]	[a]	[a]	[a]
Section	**Part B provisions**					
104	Elimination of duplicate overhead payments for outpatient services	Oct. 1, 1982	−75	−135	−175	−210
108	Reimbursement for provider-based physicians	Oct. 1, 1982	−300	−400	−480	−540
109	Prohibiting recognition of payments under certain percentage arrangements	On enactment	[a]	[a]	[a]	[a]
110	Elimination of lesser amount, either cost or charges	When HHS specifies	[a]	[a]	[a]	[a]
112	Reimbursement for inpatient radiology and pathology services	Oct. 1, 1982	−150	−210	−245	−280
113	Reimbursement for assistants at surgery	Oct. 1, 1982	−95	−125	−150	−170
114	Health maintenance organizations and other competitive medical plans	Oct. 1, 1983	0	0	[a]	[a]

Section	Part B provisions	Effective date	Fiscal years 1983	1984	1985	1986
116	Medicare secondary payor for working aged	Jan. 1, 1983	−30	−55	65	−75
124	Temporarily holding part B premium at constant percentage of cost	July 1, 1983	$−25	$−175	$−405	$−440
125	Special enrollment for merchant seamen	On enactment	[a]	[a]	[a]	[a]

Source: HCFA's Office of the Actuary.

[a]Negligible, not available, or indeterminate.

[b]Hill-Burton costs are about $15 million per year. These costs, however, are not included in the health insurance estimates.

[c]The provision will be enacted when HHS determines that it will not lead to program costs.

Table II.4: Effects of DEFRA

Dollars in millions

Section	Part A provisions	Effective date	Fiscal years 1984	1985	1986
2301	Modification of working aged	Jan. 1, 1985	$0	$−155	$−235
2308	Lesser of cost or charges	Oct. 1, 1984	[a]	[a]	[a]
2310	Limitation on increase in hospital costs per case	Oct. 1, 1984	0	0	−245
2311	Classification of certain rural hospitals	Oct. 1, 1983	0	0	0
2314	Revaluation of assets				
	Hospital		[a]	[a]	[a]
	SNF	Oct. 1, 1984	[a]	[a]	[a]
2316	PPS wage index	Oct. 1, 1983	0	0	0
2319	SNF reimbursement	Oct. 1, 1982	[a]	[a]	[a]
2320	Payment for costs of hospital-based mobile intensive care units	On enactment	[a]	[a]	[a]
2321	Cost sharing for durable medical equipment furnished as a home health benefit	On enactment	[a]	−8	−10
2322	Services of clinical psychologists provided to members of a health maintenance organization	On enactment	[a]	[a]	[a]
2337	Normalization of trust fund transfers	Sept. 1, 1984	0	0	0
2344	Medicare recovery against certain third parties	On enactment	[a]	[a]	[a]
Part	**B provisions**				
2301	Modification for working aged	Jan. 1, 1985	0	−50	−80
2302	Part B premium[b]	Jan. 1, 1986	0	109	−266
	Impact of the change in financing		0	0	−439
	Impact of all other provisions on premium income		0	109	173
2303	Payment for clinical diagnostic lab	July 1, 1984	−30	−135	−235
2304	Pacemaker reimbursement review and reform tests	Oct. 1, 1984	[a]	[a]	[a]
2305	Elimination of special payment provisions for preadmission diagnostic testing	On enactment	[a]	[a]	[a]
2306	Limit on physician fee to prevailing and customary charge levels Participating physician incentives	July 1, 1984	$−75	$−350	$−325
2307	Payment for services Teaching physicians	July 1, 1984	[a]	[a]	[a]
2309	Study of Medicare part B payments	Dec. 31, 1985	[a]	[a]	[a]

Section	Part B provisions	Effective date	Fiscal years 1984	1985	1986
2318	Emergency room services	On enactment	[a]	[a]	[a]
2323	Hepatitis B vaccine coverage	Sept. 1, 1984	0	10	5
2324	Hemophilia clotting factor	On enactment	[a]	[a]	[a]
2325	Removal of infected toenails	On enactment	[a]	[a]	[a]
2341	Includes podiatrists in definition of physician for outpatient physical therapy services; includes podiatrists and dentists in definition of physician for outpatient ambulatory surgery	On enactment	[a]	[a]	[a]

Source: HCFA's Office of the Actuary.

[a]Negligible, not available, or indeterminate.

[b]Includes impact of all sections on premium income.

Table II.5: Effects of COBRA

Dollars in millions

Section	Provisions	Effective date	Fiscal year 1986
9101	Rate of increase in payment for inpatient hospital services	May 1, 1986	$35
9102	1-year extension of PPS transition	On enactment	[a]
9104	Payment to hospitals for indirect costs of medical education	May 1, 1986	−175
9105	Payment to hospitals for disproportionate share of low-income patients	May 1, 1986	200
9107	Return on equity capital for inpatient hospital services	Oct. 1, 1986	0
9123	Extension and payment for hospice care	Apr. 1, 1986	5
9124	Limiting penalty for late enrollment in part A	July 1, 1986	[a]
9126	Access to SNFs	Oct. 1, 1986	0
9129	New Medicare coverage of state and local employees	On enactment	23
9201	Extension of working aged provisions	May 1, 1986	[a]
9202	Payment to hospitals for direct costs of medical education	July 1, 1986	20
9301	Physician payment provisions	May 1, 1986	−125
9303	Payment for clinical lab services	July 1, 1986	−5
9304	Inherent reasonableness of charges & customary charges by certain physicians	May 1, 1986	[a]
9306	Limit on payment for post-cataract surgery	Apr. 1, 1986	−10
9307	Payment for assistant at surgery for certain cataract operations	Apr. 1, 1986	−15
9313	Part B premium (income)		0

Source: HCFA's Office of the Actuary.

[a]Negligible, not available, or indeterminate.

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